FOR OHF USE

LL1

2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0033654

Facility Name: North Kickapoo

Address: 1903 North Kickapoo (Number) | Lincoln (City) | 62656 (Zip Code)

County: Logan

Telephone Number: (217) 428-7463 **Fax #** ( )

IDPA ID Number: 37-1223582002

Date of Initial License for Current Owners: 5/2/88

Type of Ownership:

[ ]	VOLUNTARY,NON-PROFIT	[X]	PROPRIETARY	[ ]	GOVERNMENTAL
[ ]	Charitable Corp.	[X]	Individual	[ ]	State
[ ]	Trust	[ ]	Partnership	[ ]	County
IRS Exemption Code		[ ]	Corporation	[ ]	Other
		[ ]	"Sub-S" Corp.		
		[ ]	Limited Liability Co.		
		[ ]	Trust		
		[ ]	Other		

In the event there are further questions about this report, please contact:
Name: Mark S. Wood, CPA **Telephone Number:** (217) 875-2655

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Kimberlea Jacobus

(Title) _____

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title) Mark S. Wood, CPA

(Firm Name & Address) May, Cocagne & King, P.C.
1353 E. Mound Road, Suite 300, Decatur, IL 62526

(Telephone) (217) 875-2655 Fax # (217) 875-1660

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number North Kickapoo # 0033654 Report Period Beginning: 1/1/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds 3/12/91

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6	16	ICF/DD 16 or Less	16	5,840	6
7	16	TOTALS	16	5,840	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS	5,498			5,498	13
14	TOTALS	5,498			5,498	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 94.14%

D. How many bed-hold days during this year were paid by Public Aid?
184 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 5/2/88

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 5/2/88 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number North Kickapoo # 0033654 Report Period Beginning: 1/1/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	28,357	3,081	1,162	32,600		32,600		32,600			1
2	Food Purchase		37,038		37,038	(3,889)	33,149		33,149			2
3	Housekeeping	32,809	3,461		36,270		36,270	20	36,290			3
4	Laundry			1,152	1,152		1,152		1,152			4
5	Heat and Other Utilities			11,254	11,254		11,254		11,254			5
6	Maintenance		1,502	12,563	14,065		14,065	1,746	15,811			6
7	Other (specify):*			3,656	3,656		3,656	236	3,892			7
8	TOTAL General Services	61,166	45,082	29,787	136,035	(3,889)	132,146	2,002	134,148			8
	B. Health Care and Programs											
9	Medical Director			3,900	3,900		3,900		3,900			9
10	Nursing and Medical Records	100,472	5,772	6,825	113,069		113,069	223	113,292			10
10a	Therapy											10a
11	Activities	17,329	10,735		28,064		28,064		28,064			11
12	Social Services	36,397		1,375	37,772		37,772		37,772			12
13	Nurse Aide Training	7,420			7,420		7,420		7,420			13
14	Program Transportation			7,018	7,018		7,018		7,018			14
15	Other (specify):*			110,801	110,801		110,801	(108,163)	2,638			15
16	TOTAL Health Care and Programs	161,618	16,507	129,919	308,044		308,044	(107,940)	200,104			16
	C. General Administration											
17	Administrative	52,100			52,100		52,100		52,100			17
18	Directors Fees											18
19	Professional Services			9,153	9,153		9,153	638	9,791			19
20	Dues, Fees, Subscriptions & Promotions			1,747	1,747		1,747	1,448	3,195			20
21	Clerical & General Office Expenses	17,275	2,539	21,083	40,897		40,897	(10,092)	30,805			21
22	Employee Benefits & Payroll Taxes			29,865	29,865	3,889	33,754		33,754			22
23	Inservice Training & Education							323	323			23
24	Travel and Seminar			693	693		693	1,983	2,676			24
25	Other Admin. Staff Transportation			865	865		865		865			25
26	Insurance-Prop.Liab.Malpractice			7,411	7,411		7,411	183	7,594			26
27	Other (specify):*											27
28	TOTAL General Administration	69,375	2,539	70,817	142,731	3,889	146,620	(5,517)	141,103			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	292,159	64,128	230,523	586,810		586,810	(111,455)	475,355			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number North Kickapoo #0033654 Report Period Beginning: 1/1/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			31,496	31,496		31,496	4,121	35,617			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			30,935	30,935		30,935	238	31,173			32
33	Real Estate Taxes			7,578	7,578		7,578		7,578			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			70,009	70,009		70,009	4,359	74,368			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers											39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			36,299	36,299		36,299		36,299			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**			36,299	36,299		36,299		36,299			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	292,159	64,128	336,831	693,118		693,118	(107,096)	586,022			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number North Kickapoo # 0033654 Report Period Beginning: 1/1/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs	(108,163)	15		3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(980)	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (109,143)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	2,047	Various	34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 2,047		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (107,096)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		X	$		38
39	Therapy		X			39
40	Gift and Coffee Shops		X			40
41	Barber and Beauty Shops		X			41
42	Laboratory and Radiology		X			42
43	Prescription Drugs		X			43
44	Exceptional Care Program		X			44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

North Kickapoo

ID# 0033654

Report Period Beginning: 1/1/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number North Kickapoo # 0033654 Report Period Beginning: 1/1/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	20	0	0	0	0	0	0	0	0	0	20	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	1,746	0	0	0	0	0	0	0	0	0	1,746	6
7	Other (specify):*	0	236	0	0	0	0	0	0	0	0	0	236	7
8	**TOTAL General Services**	0	2,002	0	0	0	0	0	0	0	0	0	2,002	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	223	0	0	0	0	0	0	0	0	0	223	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	(108,163)	0	0	0	0	0	0	0	0	0	0	(108,163)	15
16	**TOTAL Health Care and Programs**	(108,163)	223	0	0	0	0	0	0	0	0	0	(107,940)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	638	0	0	0	0	0	0	0	0	0	638	19
20	Fees, Subscriptions & Promotions	0	1,448	0	0	0	0	0	0	0	0	0	1,448	20
21	Clerical & General Office Expenses	0	(10,092)	0	0	0	0	0	0	0	0	0	(10,092)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	323	0	0	0	0	0	0	0	0	0	323	23
24	Travel and Seminar	0	1,983	0	0	0	0	0	0	0	0	0	1,983	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	183	0	0	0	0	0	0	0	0	0	183	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	0	(5,517)	0	0	0	0	0	0	0	0	0	(5,517)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(108,163)	(3,292)	0	0	0	0	0	0	0	0	0	(111,455)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number North Kickapoo # 0033654 **Report Period Beginning:** 1/1/01 **Ending:** 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	(980)	5,101	0	0	0	0	0	0	0	0	0	4,121	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	238	0	0	0	0	0	0	0	0	0	238	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(980)	5,339	0	0	0	0	0	0	0	0	0	4,359	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(109,143)	2,047	0	0	0	0	0	0	0	0	0	(107,096)	45

Facility Name & ID Number North Kickapoo # 0033654 Report Period Beginning: 1/1/01 Ending: 12/31/01

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Kimberlea B. Jacobus	100	Kimberlea B. Jacobus d/b/a Hickory Point Terrace	Forsyth,IL	Kim Jacobus		Central Office
	0	ITOS d/b/a Spring Creek Terrace - Non-Profit Corp.	Decatur, IL	Central Office	Decatur	for homes

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	21	General Office	$ 14,000	Kimberlea Jacoubs, Central Office	100.00%	$ 3,908	$ (10,092)	1
2	V	3	Housekeeping				20	20	2
3	V	5	Utilities				0		3
4	V	6	Maintenance				1,746	1,746	4
5	V	7	Other				236	236	5
6	V	10	Medical Supplies				223	223	6
7	V	19	Professional Fees				638	638	7
8	V	20	Licenses/Dues				1,448	1,448	8
9	V	23	Training				323	323	9
10	V	24	Seminars				1,983	1,983	10
11	V	26	Insurance				183	183	11
12	V	30	Depreciation				5,101	5,101	12
13	V	32	Interest				238	238	13
14	Total			$ 14,000			$ 16,047	$ * 2,047	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number North Kickapoo # 0033654 Report Period Beginning: 1/1/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Kimberlea B. Jacobus	Owner	Administrator	100.00	224,709	13	33.33	Administrator	$ 52,100	17-1	1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 52,100		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number North Kickapoo # 0033654 Report Period Beginning: 1/1/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Kimberlea Jacobus, Central Office
Street Address: 5310 East William Street
City / State / Zip Code: Decatur, Illinois 62521
Phone Number: (217) 422-6361
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	General Office	Occupied Bed Days	16,877	3	$ 11,996	$ 0	5,498	$ 3,908	1
2	3	Housekeeping	Occupied Bed Days	16,877	3	62	0	5,498	20	2
3	5	Utilities	Occupied Bed Days	16,877	3	0	0	5,498	0	3
4	6	Maintenance	Occupied Bed Days	16,877	3	5,359	0	5,498	1,746	4
5	7	Other	Occupied Bed Days	16,877	3	725	0	5,498	236	5
6	10	Medical Supplies	Occupied Bed Days	16,877	3	686	0	5,498	223	6
7	19	Professional Fees	Occupied Bed Days	16,877	3	1,957	0	5,498	638	7
8	20	Licenses/Dues	Occupied Bed Days	16,877	3	4,446	0	5,498	1,448	8
9	23	Training	Occupied Bed Days	16,877	3	990	0	5,498	323	9
10	24	Seminars	Occupied Bed Days	16,877	3	6,088	0	5,498	1,983	10
11	26	Insurance	Occupied Bed Days	16,877	3	563	0	5,498	183	11
12	30	Depreciation	Occupied Bed Days	16,877	3	15,659	0	5,498	5,101	12
13	32	Interest	Occupied Bed Days	16,877	3	731	0	5,498	238	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 49,262	$		$ 16,047	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number North Kickapoo # 0033654 Report Period Beginning: 1/1/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Soy Capital Bank		X	2000 Dodge Ram 2500	$689.45	1/31/01	$ 21,841	$ 15,746	2/2/04	8.5000	$ 1,489	1
2												2
3												3
4												4
5												5
	Working Capital											
6	National City Bank		X	Operating Cash	N/A	6/30/01	200,000	90,000	6/31/02	4.7500	3,873	6
7	Scott Cornell		X	Building Purchase	$5,156.42	4/1/98	425,000	299,760	3/31/08	8.0000	25,573	7
8												8
9	TOTAL Facility Related				$5,845.87		$ 646,841	$ 405,506			$ 30,935	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 646,841	$ 405,506			$ 30,935	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number North Kickapoo # 0033654 Report Period Beginning: 1/1/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ 7,800	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 7,578	2
3. Under or (over) accrual (line 2 minus line 1).		$ (222)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 7,800	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 7,578	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	7,567	8
	1997	7,755	9
	1998	7,715	10
	1999	7,586	11
	2000	7,578	12

2001 Accrual based on 2000 taxes

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME North Kickapoo COUNTY Logan

FACILITY IDPH LICENSE NUMBER 0033654

CONTACT PERSON REGARDING THIS REPORT Kimberlea Jacobus

TELEPHONE 217-422-6361 FAX #: 217-422-6365

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	08-029-015-50	Building & Land - 0.98 acres	$ 7,577.74	$ 7,577.74
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 7,577.74	$ 7,577.74

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number North Kickapoo # 0033654 Report Period Beginning: 1/1/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 5,000 B. General Construction Type: Exterior Brick/Vinyl Frame Rated w/Sprinklers Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Facility	8,000	1998	$ 46,725	1
2					2
3	TOTALS	8,000		$ 46,725	3

Facility Name & ID Number North Kickapoo # 0033654 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	16		1998	1988	$ 478,520	$ 12,270	25	$ 19,141	$ 6,871	$ 71,778	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Door			1991	562		26	21	21	231	9
10	Tile			1993	5,052	129	6		(129)	5,052	10
11	Flooring			1994	2,965		6			2,965	11
12	Electrical Wiring			1994	780	39	6		(39)	780	12
13	Plumbing			1995	674	17	6	38	21	674	13
14	Carpet			1996	1,419		6	236	236	1,400	14
15	Landscaping			1996	2,418	151	10	242	91	1,330	15
16	Concrete Driveway			1996	2,200	137	15	147	10	758	16
17	Curtains/Blinds			1998	3,340		10	334	334	1,336	17
18	Roof			1998	10,200	262	20	510	248	1,658	18
19	Floor Covering			2001	6,119	6,119	10	561	(5,558)	561	19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number North Kickapoo # 0033654 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 514,249	$ 19,124		$ 21,230	$ 2,106	$ 88,523	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number North Kickapoo # 0033654 Report Period Beginning: 1/1/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 41,520	$ 301	$ 3,476	$ 3,175	3-20 yrs	$ 23,911	71
72	Current Year Purchases							72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 41,520	$ 301	$ 3,476	$ 3,175		$ 23,911	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Program Transportation	1996 Dodge Ram	1999	$ Sold	$ 1,775	$	$ (1,775)	4	$	76
77	Transportation	1/2 1990 VW Cabroliet	2000	3,214	677	804	127	4	1,071	77
78	Program Transportation	2000 Dodge Ram 2500	2001	21,840	9,618	5,005	(4,613)	4	5,005	78
79										79
80	TOTALS			$ 25,054	$ 12,070	$ 5,809	$ (6,261)		$ 6,076	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 627,548	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 31,495	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 30,515	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (980)	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 118,510	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number North Kickapoo # 0033654 Report Period Beginning: 1/1/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? ☐ YES ☐ NO
   If NO, see instructions.

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number North Kickapoo # 0033654 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [X]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE 46

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)		7,420		7,420
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$ 7,420	$	$ 7,420
10	SUM OF line 9, col. 1 and 2 (e)	$ 7,420			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	18
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	18

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number North Kickapoo # 0033654 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$		$	$		$	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

STATE OF ILLINOIS

Facility Name & ID Number North Kickapoo # 0033654 Report Period Beginning: 1/1/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 2,280	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	123,171		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,380		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 130,831	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	46,725		13
14	Buildings, at Historical Cost	478,520		14
15	Leasehold Improvements, at Historical Cost	35,729		15
16	Equipment, at Historical Cost	66,575		16
17	Accumulated Depreciation (book methods)	(117,545)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 510,004	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 640,835	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 5,155	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	126,673		29
30	Accrued Salaries Payable	5,803		30
31	Accrued Taxes Payable (excluding real estate taxes)	217		31
32	Accrued Real Estate Taxes(Sch.IX-B)	7,800		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 145,648	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	278,833		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 278,833	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 424,481	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 216,354	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 640,835	$	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number North Kickapoo # 0033654 Report Period Beginning: 1/1/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 172,678	1
2	Restatements (describe):		2
3	**Rounding**	(15)	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 172,663	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	50,114	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 50,114	17
	B. Transfers (Itemize):		
18	**Auto Loan Reimbursement**	(6,423)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (6,423)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 216,354	24 *

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number North Kickapoo # 0033654 Report Period Beginning: 1/1/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 615,734	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 615,734	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education	117,197	9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	13,325	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 130,522	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 746,256	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	136,035	31
32	Health Care	308,044	32
33	General Administration	142,731	33
	B. Capital Expense		
34	Ownership	70,009	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee	36,299	36
	D. Other Expenses (specify):		
37	Loss On Sale of 1996 Dodge Van	3,024	37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 696,142	40
41	**Income before Income Taxes (line 30 minus line 40)****	50,114	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 50,114	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number North Kickapoo # 0033654 Report Period Beginning: 1/1/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing			$	$	1
2	Assistant Director of Nursing					2
3	Registered Nurses	468	468	7,148	15.27	3
4	Licensed Practical Nurses					4
5	Nurse Aides & Orderlies	10,786	10,964	93,324	8.51	5
6	Nurse Aide Trainees	779	779	7,420	9.53	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,417	1,423	12,612	8.86	9
10	Activity Assistants	610	610	4,717	7.73	10
11	Social Service Workers	1,716	1,716	36,397	21.21	11
12	Dietician	2,786	2,856	28,357	9.93	12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants					15
16	Dishwashers					16
17	Maintenance Workers					17
18	Housekeepers	3,701	3,701	32,809	8.86	18
19	Laundry					19
20	Administrator	676	676	52,100	77.07	20
21	Assistant Administrator	184	184	4,773	25.94	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	1,192	1,192	12,502	10.49	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	24,315	24,569	$ 292,159 *	$ 11.89	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	34	$ 1,162	1-3	35
36	Medical Director	Fee	3,900	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant	5	119	10-3	38
39	Pharmacist Consultant	Fee	1,700	10-3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant	17	758	10-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	8	348	10-3	43
44	Activity Consultant				44
45	Social Service Consultant	Fee	910	12-3	45
46	Other(specify) Psychologist	Fee	3,900	10-3	46
47					47
48					48
49	TOTAL (lines 35 - 48)	64	$ 12,797		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number North Kickapoo # 0033654 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kimberlea Jacobus	Administrator	100	$ 52,100
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 52,100

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
May, Cocagne & King, P.C.	Accounting/Bookkeeping	$ 8,950
Johnson Stricklin	Legal	203
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 9,153

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 4,270
Unemployment Compensation Insurance	2,271
FICA Taxes	17,590
Employee Health Insurance	4,617
Employee Meals	3,889
Illinois Municipal Retirement Fund (IMRF)*	
Simple IRA Match	1,117
TOTAL (agree to Schedule V, line 22, col.8)	$ 33,754

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	536
Health Care Worker Background Check	
(Indicate # of checks performed)	
Miscellaneous Licenses	100
Dues and subscriptions	1,111
Central Office advertising	1,423
Central Office license & fees	25
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 3,195

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	693
Central Office Seminars (All in Illinois)	1,983
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,676

* Attach copy of IMRF notifications

**See instructions.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number North Kickapoo # 0033654 Report Period Beginning: 1/1/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number North Kickapoo # 0033654 Report Period Beginning: 1/1/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **No**
If YES, give association name and amount.

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report?

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **N/A**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **0** Line

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **36,299**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **3,889** Has any meal income been offset against related costs? **No** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees.

Kimberlea B. Jacobus #0033654
d/b/a North Kickapoo
December 31, 2001

Documentation - Section V, Line 7, Column 3:

Waste Removal	1,321
Pest Control	313
Security	2,022
	3,656

Documentation - Section V, Line 15, Column 3:

Workshop	108,163
Emergency Dental Care	2,619
Optical Care	19
	110,801

Documentation - Section V, Line 24, Column 8:

Seminars and meetings	2,676

All seminar expenses were for continuing education units (CEU's) for employees relating to patient care. All seminars were attended in Illinois.

Documentation - Section V, Line 30, Column 7:

Straight-line adjustment (page 13, line 84)	(980)
Central Office	5,101
	4,121

Reclassifications - Section V, Column 5:

	From Line #	To Line #	Amount
Employee Benefits (SI	2	22	3,889

Page 7, ScheduleVII, C., Related Parties
Column 5, Compensation Received from Other Homes

Kimberlea B. Jacobus	
ITOS d/b/a Spring Ckreek Terrace	
Decatur, Illinois	110,290
Hickory Point Terrace	114,419
Forsyth, Illinois	
	224,709

Section XVII, Reconciliation of Income to Taxable Income:

Net Income (Loss) Per Books	50,114
Auto Loan Reimbursement	(6,423)
Administrator's Salary	52,100
Net Income Per Tax Return	95,791

Section XX, General Information, Question 12:

Salary costs are allocated based upon actual hours worked.